



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

James L. Carlisle, M.D.

**Respondent Name**

TPCIGA for Lumbermen's Underwriting Alliance

**MFDR Tracking Number**

M4-17-0977-01

**Carrier's Austin Representative**

Box Number 50

**MFDR Date Received**

December 7, 2016

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "DESIGNATED DOCTOR EXAMINATION NO PAYMENT RECEIVED TO DATE"

**Amount in Dispute:** \$500.00

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Following the submission of our final response on 12/22, we were notified by our bill review vendor that the bill was not able to be processed because the vendor information of Dr. Carlisle was not set up in our system to where we need a W9 from that facility in order to add his information and have the bill paid ... To date, I have not received anything from this provider."

**Response Submitted by:** Texas Property & Casualty Guaranty Association

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 8, 2016	Designated Doctor Examination	\$500.00	\$500.00

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services provided from March 1, 2008 until September 1, 2016.
3. Submitted documentation does not include explanations of benefits.

## **Issues**

Is James L. Carlisle, M.D. entitled to reimbursement of the services in question?

## **Findings**

James L. Carlisle, M.D. is seeking reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating performed on February 8, 2016. Review of submitted documentation finds that TPCIGA for Lumbermen's Underwriting Alliance (TPCIGA) failed to present a denial for the services in question prior to the submission of a request for medical fee dispute. Absent any defenses raised prior to medical fee dispute resolution, Dr. Carlisle is eligible for reimbursement as following:

Per 28 Texas Administrative Code §134.204(j)(3), "The following applies for billing and reimbursement of an MMI evaluation... (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350." The submitted documentation supports that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the maximum allowable reimbursement (MAR) for this examination is \$350.00.

28 Texas Administrative Code §134.204(j)(4)(D) states that:

- (i) Non-musculoskeletal body areas are defined as follows:
  - (I) body systems;
  - (II) body structures (including skin); and,
  - (III) mental and behavioral disorders.
- (ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides...
- (v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be \$150.

Review of the submitted documentation finds that the requestor performed an impairment rating evaluation of the left eye. Therefore, the correct MAR for this examination is \$150.00.

The total MAR for the services in question is \$500.00. This amount is recommended.

## **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$500.00.

## ***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$500.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

## **Authorized Signature**

	Laurie Garnes	March 3, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**